

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04956

CERTIFICATE OF DEATH

Reg. Dist. No. 280

1. PLACE OF DEATH COUNTY <u>Kent</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u>		COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS			
TOWN <u>Mallington</u>		<u>year</u>		TOWN <u>Mallington</u>		<u>Mallington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS									
3. NAME OF DECEASED (Type or Print)	(First) <u>Belvin</u>	(Middle) <u>Syretis</u>	(Last) <u>Bentley</u>	4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>24</u>	(Year) <u>1967</u>		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. UNDER 1 year yrs. <u>9</u>	11. Months <u>9</u>	12. Days <u>0</u>	13. If under 24 hrs. Hours <u>0</u>	14. If under 24 hrs. Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? <u>yes</u>				
<u>none</u>		<u>—</u>		<u>Mallington</u>					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
<u>Albert - Bentley</u>		<u>Johanna Huchea</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION			
		<u>—</u>		<u>Johanna Bentley, Mallington</u>					

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Brach pneumoniaINTERVAL BETWEEN
ONSET AND DEATH3 days

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

 Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month)	(Day)	(Year)	INJURY OCCURRED While at Work <input type="checkbox"/>	Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY	m.				

22. I hereby certify that I attended the deceased from Medical attention, that I last saw the deceased alive on May 24, 1957, and that death occurred at 7:10 a.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)
<u>Burial</u>	<u>5/27/51</u>	<u>Mallington Crem. Co.</u>	<u>Mallington</u>
DATE REC'D BY LOCAL REG.	REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>5/26/51</u>		<u>Edward Fellows</u>	ADDRESS
208250299405			

RECEIVED

JUN 4 1951

FBI BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04957

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH: COUNTY <i>Kent</i> COUNTY <i>MARYLAND</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Baltimore</i> COUNTY <i>Kent</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Norton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Mary</i> (Middle) <i>Jane</i>	(Last) <i>Harris</i>	4. DATE OF DEATH <i>May 9</i> 1951
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Jan 8 1904</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>170X</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Telephone Office Norton and Rural</i>	9. AGE last birthday <i>47</i> yrs. If under 1 year Months Days Hours Min.
13. FATHER'S NAME <i>James J. Harris</i>		11. BIRTHPLACE (State or foreign country) <i>Worlton and Rural</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>197-09-8246</i>	14. MOTHER'S MAIDEN NAME <i>Katherine Parsons</i>
17. INFORMANT <i>Edgar Harris</i>		18. MEDICAL CERTIFICATION	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <i>Secondary Anemia</i>		<i>18 mo.</i>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>170X</i> <i>50</i>		<i>1949.</i>
(a) <i>Carcinoma of Breast</i> (b) <i>Metastasis through Lungs</i>		<i>18 mo.</i>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <i>1949 Aug</i>	19b. MAJOR FINDINGS OF OPERATION <i>Cancer of Breast - Neck S.C.</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) <i>Worlton</i> (COUNTY) <i>Kent</i> (STATE) <i>MD</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May 1*, 1951, to *May 9*, 1951, that I last saw the deceased alive on *May 7*, 1951, and that death occurred at *2 P.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED *5/9/51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>May 11, 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Still Pond</i>	LOCATION (City, town, or county) <i>Still Pond</i> (State) <i>MD</i>
DATE REC'D BY LOCAL REG.	REG. <i>May 9, 1951</i>	REGISTRAR'S SIGNATURE <i>Clara S. Barnes</i>	24. FUNERAL DIRECTOR ADDRESS <i>13 B Crabb's Still Pond Rd.</i>

RECEIVED
APR 14 1951
GARDEN V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04958

201

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		LENGTH OF STAY (in this place)		Md.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Kenssedyville		Kenssedyville		Kenssedyville (Rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) J	(Middle)	ROGER KENNEDY		(Last)	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	10. under 1 year Months. Days Hours
male		white	Comm. Handling	Feb 14 1893		59	11. under 24 hrs. Months. Days Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Tucker		Comm. Handling		Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.	
Alexander Kennedy		Mary E. Gill		Yes		17. INFORMANT AND ADDRESS	
17. ADDRESS		Kenssedyville Md.		94a		18. MEDICAL CERTIFICATION	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Immediate cause (a) Coronary Thrombosis		Antecedent cause(s) (b) Coronary Insufficiency		19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
20. DATE OF OPERATION		21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		22. I hereby certify that I attended the deceased from alive on SIGNATURE DATE REC'D BY LOCAL REG.	
20. AUTOPSY?		TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work		23. BURIAL/CREMATION LOCAL (Specify)	
Yes <input type="checkbox"/> No <input type="checkbox"/>		m.		Not While At work		DATE	
24. FUNERAL DIRECTOR ADDRESS		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county)		(State)	
Edward Pillows Millington Md.		Hill Pond		Hill Pond		Md.	
DATE REC'D BY LOCAL REG.		REGISTER'S SIGNATURE		683536		ADDRESS	





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04960

CERTIFICATE OF DEATH

Reg. Dist. No. 204

VS. A15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Kent	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN near Rock Hall		LENGTH OF STAY (in this place) life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock Hall		STREET ADDRESS Rural (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural							
3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) L.	(Last) Shirley	4. DATE OF DEATH May 24, 1951	(Month) 19	(Day) 24	(Year) 1951
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married	8. DATE OF BIRTH Nov. 11, 1883	9. AGE last birthday 67	If under 1 year Months. yrs.	If under 24 hrs. Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob Shirley		14. MOTHER'S MAIDEN NAME Emma Lamb					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	17. INFORMANT AND ADDRESS Mrs. Stanley Sutton		Chestertown Md.		
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause 422.2 Antecedent cause(s)		(a) Myocarditis Arthritis Arthritis, exposure					
Diseases or conditions, if any, giving rise to the above cause 93e stating the underlying cause last		(b) (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/25</u> , 19 <u>51</u> , to <u>5/24</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>51</u> , and that death occurred at <u>1-30 P</u> m., from the causes and on the date stated above.							
SIGNATURE <u>D. Keeler</u>		(Degree or title) ADDRESS <u>Rock Hall</u>		DATE SIGNED <u>5/25/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>May 26, 1951</u>		NAME OF CEMETERY OR CREMATORIAL <u>Chester Cem</u>		LOCATION (City, town, or county) <u>Chestertown, Md.</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>May 26/51</u>		REGISTRAR'S SIGNATURE <u>J. W. Smith</u>		24. FUNERAL DIRECTOR <u>J. Willis Wells - Chestertown, Md.</u>		ADDRESS <u>100105</u>	

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MAY 31 1951

BUREAU X-8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04961

203

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MARYLAND Rock Hall	2. USUAL RESIDENCE (HOME) OF DECEASED- CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MARYLAND Rock Hall
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Home	STREET ADDRESS	(If rural give location)

3. NAME OF DECEASED (Type or Print)	(First) <i>Elvira</i>	(Middle) <i>R.</i>	(Last) <i>Taylor</i>	4. DATE OF DEATH	(Month) <i>May</i>	(Day) <i>29</i>	(Year) <i>1951</i>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH	9. AGE last birthday yrs.	If under 1 year Months	If under 24 hrs. Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Rock Hall</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13. FATHER'S NAME <i>Michael Webb</i>	14. MOTHER'S MAIDEN NAME <i>Rachel Sauter</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>220</i>
17. INFORMANT <i>Elwood Taylor</i>	18. MEDICAL CERTIFICATION <i>myocardial degeneration</i>

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <i>443X</i>	(a) <i>myocardial degeneration</i>	INTERVAL BETWEEN ONSET AND DEATH
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause <i>93d</i>	(b) <i>Asthma</i>	
	(c) <i>Hypertension</i>	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?		
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *May 20, 1951*, to *May 29, 1951*, that I last saw the deceased alive on *May 22, 1951*, and that death occurred at *10 P* m., from the causes and on the date stated above.

SIGNATURE *Wester MA* ADDRESS DATE SIGNED *Rock Hall June 1/51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR GREMATORIAL REG. <i>Crem</i>	LOCATION (City, town, or county) ADDRESS
DATE REC'D BY LOCAL REG. <i>June 1-51</i>	REGISTRAR'S SIGNATURE <i>Elwood Binger</i>	24. FUNERAL DIRECTOR ADDRESS	

RECEIVED

JUN 7 1951

BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04962

CERTIFICATE OF DEATH

Reg. Dist. No. 203

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY <i>Hanover Co</i>	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Rural Rock Hall</i>	LENGTH OF STAY (in this place) <i>6 years</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS <i>Rural Rock Hall and</i>

3. NAME OF DECEASED (Type or Print)	(First) <i>Eda</i>	(Middle) <i>Josephine</i>	(Last) <i>Apsley</i>	4. DATE OF DEATH <i>May 21</i>	(Month) <i>May</i>	(Day) <i>21</i>	(Year) <i>1951</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>November 3 1866</i>	9. AGE last birthday <i>90</i>	If under 1 year Months Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Isaac A. Apsley</i>	14. MOTHER'S MAIDEN NAME <i>Susan Alodia Apsley</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or forces of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>123-45-6789</i>	17. INFORMANT <i>Missouri Taylor Carroll</i>			

18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <i>Myocardial Degeneration</i>							
422.2 Antecedent cause(s) (b) <i>Ischaemic heart disease</i>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>93d</i>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <i>5/22/51</i>	19b. MAJOR FINDINGS OF OPERATION <i>✓</i>						
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE <i>No</i>	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>Office</i>	(CITY OR TOWN) <i>Rock Hall</i>		(COUNTY) <i>Rock Hall</i>		(STATE) <i>Md</i>
TIME (Month) OF INJURY <i>5/23/51</i>	(Day) <i>10</i>	(Year) <i>1951</i>	(Hour) <i>10</i>	INJURY OCCURRED While at m. <i>Work</i>	Not While <i>At work</i>	HOW DID INJURY OCCUR? <i>From a fall</i>	

22. I hereby certify that I attended the deceased from *May 1, 1951*, to *May 21, 1951*, that I last saw the deceased alive on *May 20, 1951*, and that death occurred at *2:30 a.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>5/23/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Rock Hall</i>	LOCATION (City, town, or county) <i>Rock Hall</i>	(State) <i>Md</i>
DATE REC'D BY LOCAL REG. <i>5/22/51</i>	REGISTRAR'S SIGNATURE <i>S. Elwood Burgess</i>	24. FUNERAL DIRECTOR <i>K3</i>		
ADDRESS <i>Millerton</i>		ADDRESS <i>Millerton</i>		

REVIEWED
MAY 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04963

CERTIFICATE OF DEATH

Reg. Dist. No. 2 02

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <i>Kent</i>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <i>Md</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Butlerown</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS <i>Millington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Kent & Queen Anne Hospital</i>			
3. NAME OF DECEASED (Type or Print)	(First) <i>ISAAC</i>	(Middle) <i>Colored</i>	(Last) <i>THOMAS</i>
4. SEX <i>Male</i>	5. COLOR OR RACE <i>Colored</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Widowed</i>	7. DATE OF BIRTH <i>1881</i>
8. AGE last birthday yr. <i>70</i>	9. DATE OF DEATH <i>May 19 1951</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY <i>USA</i>	13. FATHER'S NAME <i>unknown</i>	14. MOTHER'S MAIDEN NAME <i>unknown</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of <i>Service unknown</i>
16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT AND ADDRESS <i>Jessie Jones Rural Worthington Md.</i>	18. MEDICAL CERTIFICATION <i>Chronic Cardiovascular Disease Generalized Arteriosclerosis Bronchial Asthma</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <i>422.1</i> Antecedent cause(s) (b) <i>unknown</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>93d</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Bronchial Asthma</i>			
19a. DATE OF OPERATION <i>—</i>	19b. MAJOR FINDINGS OF OPERATION <i>—</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE <i>—</i>	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <i>—</i>	(CITY OR TOWN) <i>—</i>	(COUNTY) <i>—</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>—</i>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> <i>—</i>	HOW DID INJURY OCCUR? <i>—</i>	
22. I hereby certify that I attended the deceased from <i>4/11/51</i> to <i>5/19</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>5/19</i> , 19 <i>51</i> , and that death occurred at <i>11:20</i> a.m., from the causes and on the date stated above. SIGNATURE <i>J. H. Hamilton</i> (Degree or title) <i>M.D.</i> ADDRESS <i>Millington Md.</i> DATE SIGNED <i>5/21/51</i>			
23. BURIAL, CREMATION RETRIVAL (Specify) <i>Burial</i>	DATE THEREOF <i>May 23/1951</i>	NAME OF CEMETERY OR CREMATORIUM <i>Butlerown Cem.</i>	LOCATION (City, town, or county) <i>Butlerown</i>
DATE REC'D BY LOCAL REG. <i>May 23-1951</i>	REGISTRAR'S SIGNATURE <i>Clara S. Barnes.</i>	24. FUNERAL DIRECTOR <i>Edward Fellow Millington Md.</i>	ADDRESS <i>—</i>

RECEIVED
MAY 28 1951
FBI BUREAU W. S.